RECIPIENT ELIGIBILITY

Eligibility Determination

For most recipients, Medicaid eligibility is determined by the local department of social services (DSS) in the county in which the individual resides. Applicants may enroll in person or by mail. Applicants for Medicaid are evaluated on income level, available financial resources, and criteria related to categorical standards such as age and disability. Families receiving Work First Family Assistance and individuals receiving Special Assistance benefits also receive Medicaid.

If a household's income exceeds the allowable level, the applicant may be eligible for Medicaid after sufficient medical expenses are incurred that would meet a deductible. The deductible is calculated using a formula set in law.

Aged, blind, and disabled individuals (including children) who receive Supplemental Security Income (SSI) are automatically entitled to N.C. Medicaid benefits and are not required to make a separate Medicaid application at the county DSS office. SSI eligibility is determined by the Social Security Administration. If an SSI recipient needs Medicaid coverage prior to the effective date of the SSI coverage, the recipient may apply for this coverage at the county DSS office. The recipient must apply for retroactive SSI Medicaid within 60 days (90 days with good cause) from the date of the SSI Medicaid approval or denial notice in order to protect the SSI retroactive period.

Eligibility Categories

North Carolina Medicaid recipients receive benefits in the following assistance categories:

- Medicaid - Work First Family Assistance (AAF)
- Medicaid - Aid to the Aged (MAA)
- Medicaid - Aid to the Blind (MAB)
- Medicaid - Aid to the Disabled (MAD)
- Medicaid – Families and Children (MAF)
- Medicaid - Infants and Children (MIC)
- Medicaid - Pregnant Women (MPW)
- Medicaid - Special Assistance to the Blind (MSB)
- Foster Care; Adoption Subsidy (HSF; IAS)
- Special Assistance - Aid to the Aged (SAA)
- Special Assistance - Aid to the Disabled (SAD)
- Medicaid - Medicare-Qualified Beneficiaries (MQB)
- Medicaid - Refugees (MRF)
- Medicaid - Refugee Assistance (RRF)

Providers who have general eligibility questions should call their local county DSS.

When Does Eligibility Begin

An individual is eligible for Medicaid the **month** in which all categorical and financial conditions of eligibility are met. If all requirements are met on the first day of the month, eligibility begins that day.

If the individual has a deductible or excess resources and all other conditions are met, eligibility begins on the **day** of the month the deductible is met or the resource is reduced to the allowable limit. The Medicaid deductible is met by incurring medical expenses, **which the individual is responsible for paying** from personal funds, during the certification period in which assistance is requested. The Medicaid certification period (the period for which the deductible is computed) is typically six months.

Eligibility for nonqualified alien residents is approved for emergency services only and is limited to only the services required to treat the emergency condition. To be eligible for emergency services, the individual must still meet all other eligibility requirements, such as income, resources, age, and/or disability criteria.

Eligibility for most recipients ends on the last day of the month. Exceptions to this are a presumptively eligible pregnant woman whom the county DSS has determined to be ineligible and a nonqualified alien eligible to receive emergency service only.

Retroactive Eligibility

Retroactive coverage may be approved for up to three calendar months prior to the month of the application if the applicant meets all eligibility conditions in the retroactive period. Medicaid will pay for covered services received during the retroactive period provided that all other Medicaid guidelines are met. Providers may choose to accept or decline retroactive eligibility. However, the provider's office policy should be consistently enforced. If a provider accepts retroactive eligibility, all payments made by the recipient must be reimbursed to the recipient when the provider files the claim to Medicaid.

Eligibility Reversals

In some cases an application for Medicaid benefits is initially denied and then later approved due to a reversal of a disability denial, a state appeal or a court decision. Because some of these appeals and reversals are not final for many months, the county DSS can request an override of the claims filing time limit from DMA. Written notice is provided to the recipient and to the county DSS when the time limit override is approved. Recipients are instructed to immediately notify the provider of retroactive approval. Failure to do so will result in the recipient being financially liable for the services provided. Refer to **Eligibility Denials** on page 2-12 for additional information.

Medicaid Identification Cards

Individuals approved for Medicaid receive a monthly Medicaid identification (MID) card as proof of their eligibility. The MID card indicates eligibility coverage and restrictions that apply to the recipient. The MID card shows information necessary for filing claims, including the recipient's MID number, date of birth, insurance information, Medicaid Managed Care information, and recipient eligibility dates for which the card is valid.

A recipient's eligibility and managed care provider may change from month to month. Therefore, new MID cards are issued at the beginning of each month. The new card shows valid eligible dates through the current calendar month. The "From" date may show eligibility for prior months in addition to the current calendar month.

Providers must request that recipients present their current MID card as proof of eligibility for the dates of services rendered. Recipients must present a valid MID card at each provider visit. Failure to provide proof of eligibility may result in the recipient being financially liable for the service provided as the provider can refuse to accept the recipient as a Medicaid client.

Blue and Pink Medicaid Identification Card Information, continued

Field	Description
Insurance Number	A number in this field indicates that the recipient has specific third party insurance.
Name Code	A 3-digit code identifies the name of the third party insurance carrier. **Note:** The **Third Party Insurance Code book** is available on DMA's website at http://www.dhhs.state.nc.us/dma/tpr.html and provides a key to the insurance codes listed in this field.
Policy Number	If the recipient has coverage with a third party insurance carrier, the recipient's insurance policy number is listed in this field.
Type	A 2-digit code indicates the type of coverage provided in the policy. The type of coverage codes are listed below: 00 - Major Medical Coverage 01 - Basic Hospital with Surgical Coverage 03 - Dental Coverage Only 02 - Basic Hospital Only Coverage 04 - Cancer Only Coverage 05 - Accident Only Coverage 06 - Indemnity Only Coverage 07 - Nursing Home Only Coverage 08 - Basic Medicare Supplement 10 - Major Medical and Dental Coverage 11 - Major Medical and Nursing Home Coverage 12 - Intensive Care Only Coverage 13 - Hospital Outpatient Only Coverage 14 - Physician Only Coverage 15 - Heart Attack Only Coverage 16 - Prescription Drugs Only Coverage 17 - Vision Care Only Coverage

Recipient Name and Address	The name and address of the head of the household is listed to the right of the Insurance Data.
Recipient Name and Address – Carolina ACCESS (CCNC) Enrollees	If the recipient is enrolled with CA (CCNC) or a Medicaid HMO, the words "Carolina ACCESS Enrollee" or "Prepaid Health Plan Enrollee" appear on the card.
Date	The month and the year that the card was issued for are listed here.
Signature	The recipient must sign the MID card where indicated.

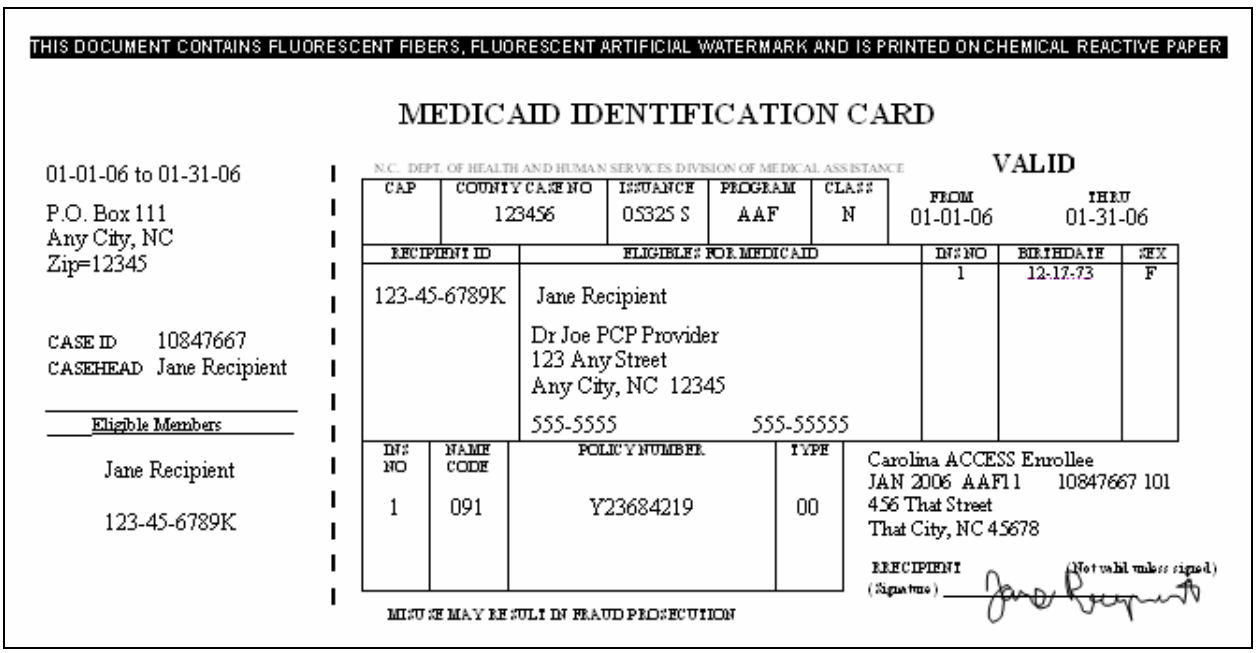
Blue Medicaid Identification Card

The card lists the casehead of the family and other eligible persons. Each eligible recipient has a specific recipient MID number. A recipient is only eligible for Medicaid if his/her name and MID number appear on the card.

CA (CCNC) enrollees are identified by the phrase "Carolina ACCESS Enrollee" on the MID card. The name of the CA (CCNC) PCP, the PCP's address, and the daytime and after-hours telephone numbers for the practice are also listed on the card. The date listed under the phrase "Carolina ACCESS Enrollee" indicates that the recipient is enrolled with the PCP listed on the card for that month. Providers must contact the PCP listed on the recipient's MID card to obtain referral and authorization before providing treatment.

HMO enrollees are identified by the phrase "Prepaid Health Plan Enrollee" on the MID card. The name of the health plan, the address, and the member services phone number are also listed on the card. Providers must contact the health plan listed on the recipient's MID card to obtain referral authorization before providing treatment. (HMO enrollees also receive a membership card from the health plan.)

Refer to **Carolina ACCESS Referrals and Authorization** on page 4-11 for additional information on Managed Care referrals.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MEDICAID IDENTIFICATION CARD

01-01-06 to 01-31-06

P.O. Box 111
Any City, NC
Zip=12345

CASE ID 10847667
CASEHEAD Jane Recipient

Eligible Members

Jane Recipient

123-45-6789K

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

VALID

CAP	COUNTY CASE NO	ISSUANCE	PROGRAM	CLASS	FROM	THRU
	123456	05325 S	AAF	N	01-01-06	01-31-06

RECIPIENT ID	ELIGIBLES FOR MEDICAID	IN# NO	BIRTHDATE	SEX
123-45-6789K	Jane Recipient	1	12-17-73	F

Dr Joe PCP Provider
123 Any Street
Any City, NC 12345

555-5555 555-55555

IN# NO	NAME CODE	POLICY NUMBER	TYPE
1	091	Y23684219	00

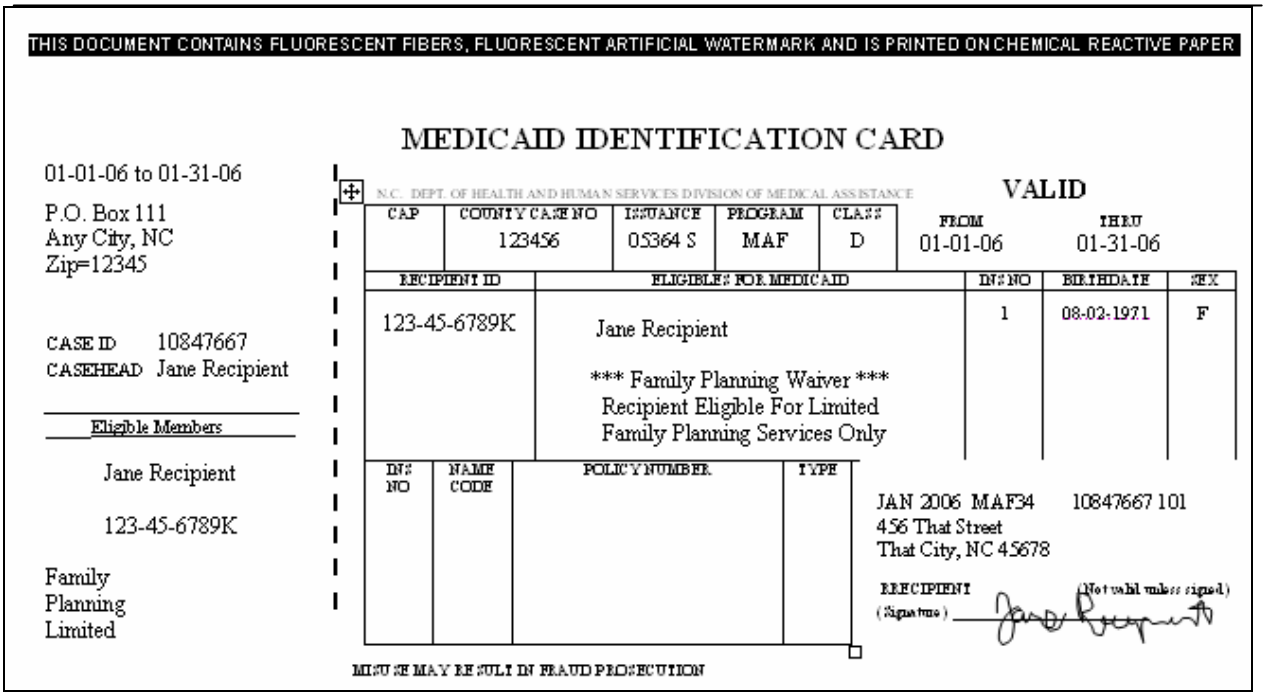
Carolina ACCESS Enrollee
JAN 2006 AAF11 10847667 101
456 That Street
That City, NC 45678

RECIPIENT (Signature) (Not valid unless signed)

MISUSE MAY RESULT IN FRAUD PROSECUTION

Family Planning Waiver Card

Family Planning Waiver - If the recipient is eligibility for the Family Planning Waiver (MAF-D) the words "FAMILY PLANNING WAIVER. Recipient eligible for LIMITED Family Planning Services Only" appear on the card. The words "FAMILY PLANNING LIMITED" appear on the pharmacy stub.



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MEDICAID IDENTIFICATION CARD

01-01-06 to 01-31-06

P.O. Box 111
Any City, NC
Zip=12345

CASE ID 10847667
CASEHEAD Jane Recipient

Eligible Members

Jane Recipient

123-45-6789K

Family
Planning
Limited

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

VALID

CAP	COUNTY CASE NO	ISSUANCE	PROGRAM	CLASS	FROM	THRU
	123456	05364 S	MAF	D	01-01-06	01-31-06

RECIPIENT ID	ELIGIBLES FOR MEDICAID	DN# NO	BIRTHDATE	SEX
123-45-6789K	Jane Recipient *** Family Planning Waiver *** Recipient Eligible For Limited Family Planning Services Only	1	08-02-1971	F

DN# NO	NAME CODE	POLICY NUMBER	TYPE

JAN 2006 MAF34 10847667 101
456 That Street
That City, NC 45678

RECIPIENT (Signature) (Not valid unless signed)

MISUSE MAY RESULT IN FRAUD PROSECUTION

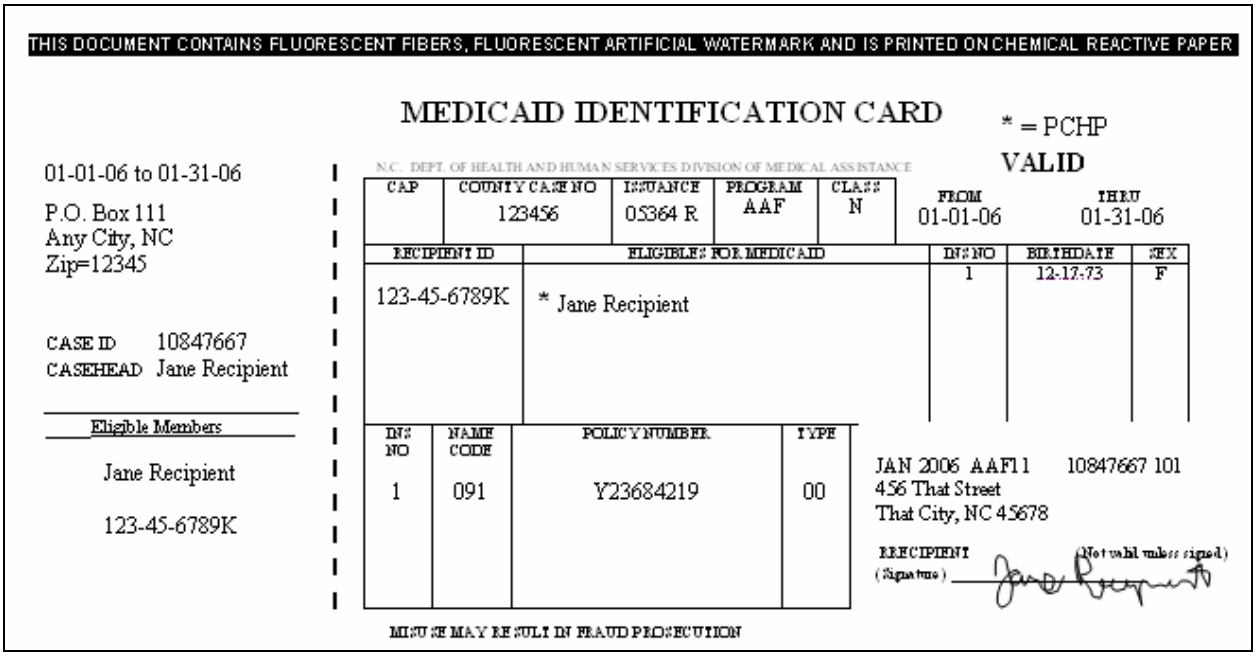
Piedmont Cardinal Health Plan Card

Effective April 1, 2005, Piedmont Behavioral Healthcare began operating under a managed care plan which applies to Medicaid recipients who get their Medicaid cards from Rowan, Stanly, Union, Davidson, and Cabarrus counties. The new managed care plan is known as Piedmont Cardinal Health Plan (PCHP). All Medicaid mental health, development disabilities and substance abuse (MH/DD/SA) services for individuals receiving Medicaid from one of the five counties listed above are provided through PCHP. This includes services in the Innovations waiver, which replaces CAP-MR/DD in the five-county Piedmont area.

PCHP is paid a flat, per-member-per-month payment and PCHP in turn arranges and pays for MH/DD/SA services for recipients in the catchment area. DMA does not authorize, prior approve or reimburse individual providers for these services.

All Medicaid recipients in the catchment area are covered by the PCHP with the exception of the following groups:
- Medicare Qualified Beneficiaries
- Refugees
- Non-qualified aliens or qualified aliens during the five year ban

If the recipient is enrolled in the Piedmont Cardinal Health Plan, the letters "PCHP" are printed on the card. If the recipient is enrolled in the Innovations plan, both "PCHP" and "CM" or simply "CM" are printed on the card. All behavioral health services for recipients participating in PCHP or CM or both must be approved by PCHP in order for the provider to be reimbursed



Providers who are interested in applying to participate in the PCHP network should call Piedmont Provider Relations at 1-800-958-5596.

Pink Medicaid Identification Card

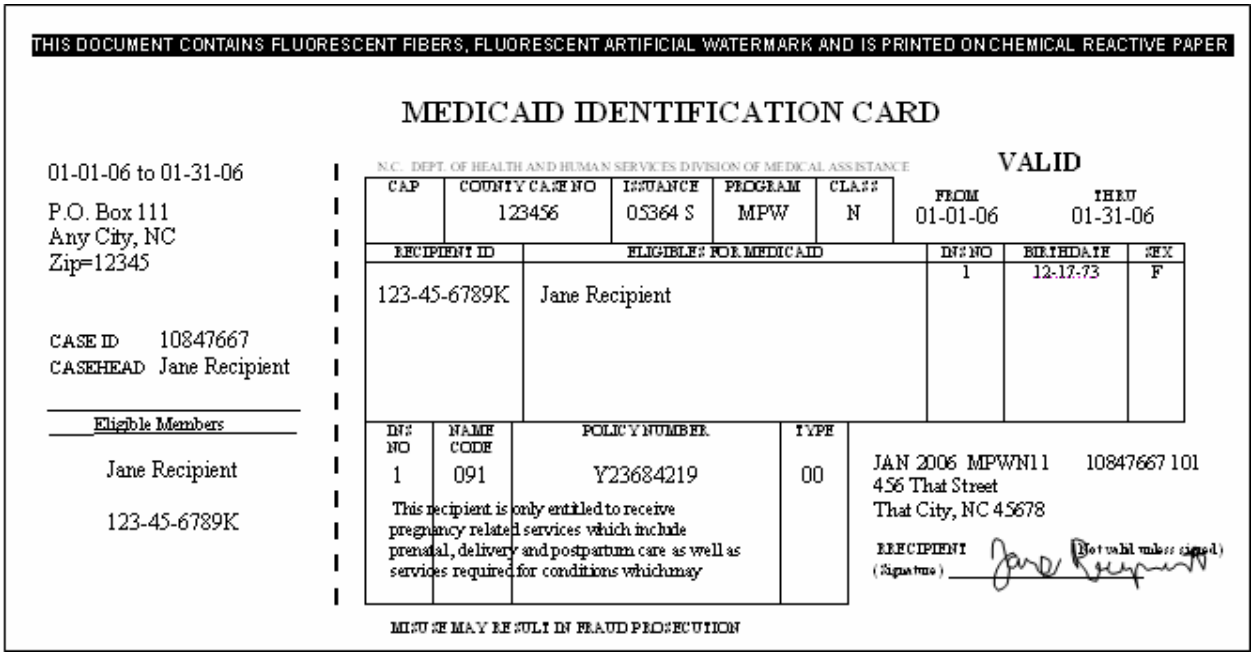
The pink MID card indicates the recipient is eligible for pregnancy-related services only. Only the name of the eligible pregnant woman is listed on the card. No other recipients are listed on the card. A message is printed on the card stating that eligibility is limited to services relating to pregnancy and conditions that may complicate the pregnancy. If a second message appears on the MID card stating the recipient is presumptively eligible only, coverage is limited to ambulatory care.

CA (CCNC) enrollees are identified by the phrase "Carolina ACCESS Enrollee" on the MID card. The name of the CA (CCNC) PCP, the PCP's address, and the daytime and after-hours telephone numbers for the practice are also listed on the card. The date listed under the phrase "Carolina ACCESS Enrollee" indicates that the recipient is enrolled with the PCP listed on the card for that month. Providers must contact the PCP listed on the recipient's MID card to obtain referral and authorization before providing treatment.

HMO enrollees are identified by the phrase "Prepaid Health Plan Enrollee" on the MID card. The name of the health plan, the address, and the member services phone number are also listed on the card. Providers must contact the health plan listed on the recipient's MID card to obtain referral authorization before providing treatment. (HMO enrollees also receive a membership card from the health plan.)

Refer to **Carolina ACCESS Referrals and Authorization** on page 4-11 for additional information on Managed Care referrals.

If the recipient is enrolled in the Piedmont Cardinal Health Plan, the letters "PCHP" are printed on the card. If the recipient is enrolled in the Innovations plan, both "PCHP" and "CM" or simply "CM" are printed on the card. All behavioral health services for recipients participating in PCHP or CM or both must be approved by PCHP in order for the provider to be reimbursed.



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MEDICAID IDENTIFICATION CARD

01-01-06 to 01-31-06

P.O. Box 111
Any City, NC
Zip=12345

CASE ID 10847667
CASEHEAD Jane Recipient

Eligible Members

Jane Recipient

123-45-6789K

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

VALID

CAP	COUNTY CASE NO	ISSUANCE	PROGRAM	CLASS	FROM	THRU
	123456	05364 S	MPW	N	01-01-06	01-31-06

RECIPIENT ID	ELIGIBLE FOR MEDICAID	IN# NO	BIRTHDATE	SEX
123-45-6789K	Jane Recipient	1	12-12-73	F

IN# NO	NAME CODE	POLICY NUMBER	TYPE
1	091	Y23684219	00

This recipient is only entitled to receive pregnancy related services which include prenatal, delivery and postpartum care as well as services required for conditions which may

JAN 2006 MPWN11 10847667 101
456 That Street
That City, NC 45678

RECIPIENT (Signature) _____ (Not valid unless signed)

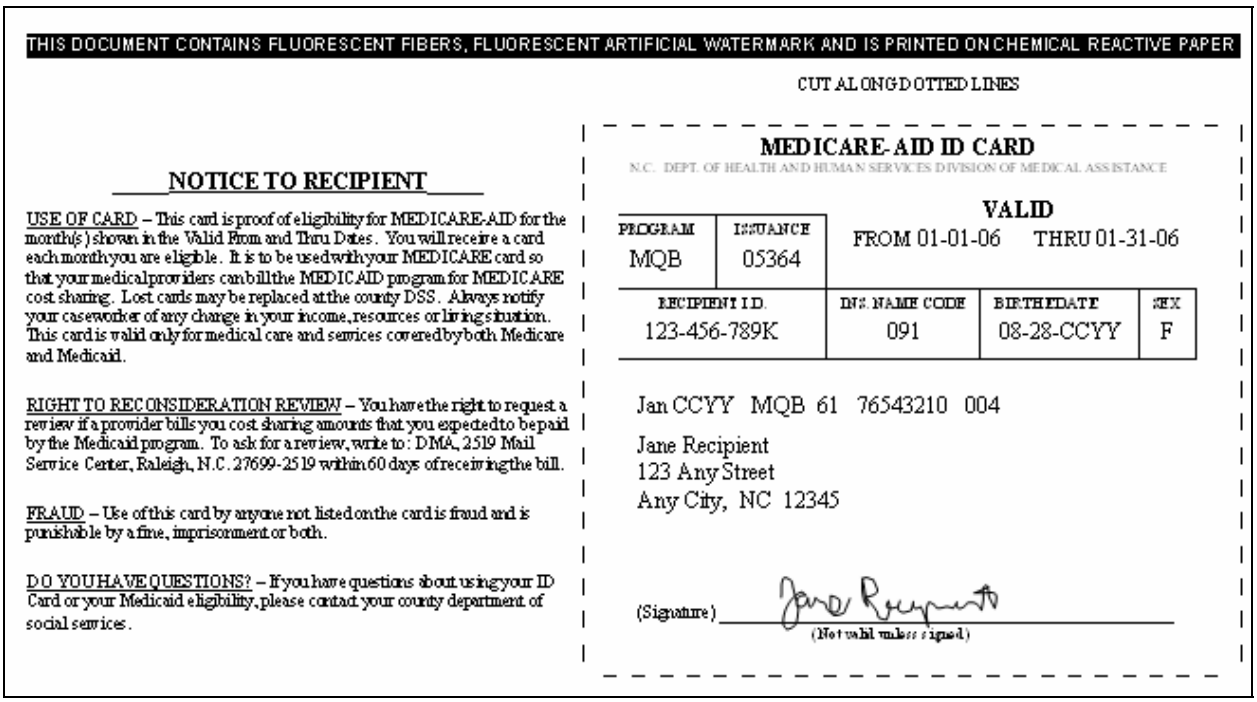
MISUSE MAY RESULT IN FRAUD PROSECUTION

Buff MEDICARE-AID ID Card Information

Field	Description
Program	The 3-character code indicates the recipient's coverage category.
Issuance	The 5-digit Julian date and letter (R or S) indicates the date that the card was prepared and when the card was mailed.
Valid From - Thru	The From and Thru dates indicate the eligibility period. The From date may show eligibility for prior months in addition to the current calendar month. The Thru date is the last day of eligibility in the current month.
Recipient ID	This refers to the unique MID number assigned to the recipient. The MID number is a 9-digit number followed by an alpha character.
Insurance Name Code	A 3-digit code identifies the name of the third party insurance carrier. **Note:** The **Third Party Insurance Code book** is available on DMA's website at http://www.dhhs.state.nc.us/dma/tpr.html and provides a key to the insurance codes listed in this field.
Birth Date	The recipient's date of birth is listed by the month, day, and year.
Sex	The recipient's gender is listed in this field.
County Number	A 2-digit code indicates the county that issued the card to the recipient.
Case Identification Number	An 8-digit number is assigned to the head of the household. (Refer to this number when requesting assistance from the recipient's county DSS office.)
County District Number	A 3-digit number indicates the district. This information is only used by the county.
Recipient Name and Address	The name and address of the head of the household is listed in this area.
Signature	The recipient must sign the MID card where indicated.

Buff MEDICARE-AID ID Card

The buff-colored MEDICARE-AID ID card, referred to as the Medicare Qualified Beneficiary (MQB-Q class) card, indicates the recipient is eligible for the MEDICARE-AID program. If both Medicare and Medicaid allow the service, Medicaid will pay the lower of the Medicare cost-sharing amount or the Medicaid maximum allowable for the service less the Medicare payment. Recipients with a buff MEDICARE-AID ID card are not eligible to enroll in Medicaid Managed Care programs.



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CUT ALONG DOTTED LINES

NOTICE TO RECIPIENT

USE OF CARD – This card is proof of eligibility for MEDICARE-AID for the month(s) shown in the Valid From and Thru Dates. You will receive a card each month you are eligible. It is to be used with your MEDICARE card so that your medical providers can bill the MEDICAID program for MEDICARE cost sharing. Lost cards may be replaced at the county DSS. Always notify your caseworker of any change in your income, resources or living situation. This card is valid only for medical care and services covered by both Medicare and Medicaid.

RIGHT TO RECONSIDERATION REVIEW – You have the right to request a review if a provider bills you cost sharing amounts that you expected to be paid by the Medicaid program. To ask for a review, write to: DMA, 2519 Mail Service Center, Raleigh, N.C. 27699-2519 within 60 days of receiving the bill.

FRAUD – Use of this card by anyone not listed on the card is fraud and is punishable by a fine, imprisonment or both.

DO YOU HAVE QUESTIONS? – If you have questions about using your ID Card or your Medicaid eligibility, please contact your county department of social services.

MEDICARE-AID ID CARD

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

VALID

PROGRAM	ISSUANCE	FROM	THRU
MQB	05364	01-01-06	01-31-06

RECIPIENT I.D.	INS. NAME CODE	BIRTHDATE	SEX
123-456-789K	091	08-28-CCYY	F

Jan CCYY MQB 61 76543210 004

Jane Recipient
123 Any Street
Any City, NC 12345

(Signature) Jane Recipient
(Not valid unless signed)

NOTICE TO PROVIDERS

ENROLLMENT – To receive payment you must be enrolled with Medicare and North Carolina Medicaid. If not enrolled, call DMA Provider Services at 919-855-4050 for information and forms.

BENEFITS – Medicaid coverage for the recipient of this card is limited to Medicare cost sharing for Medicare and Medicaid covered services. If your services are not billable to Medicare, you cannot bill the Medicaid Program for services for this recipient.

USE OF CARD – Use this card with the recipient's MEDICARE card as proof of eligibility for MEDICARE-AID benefits.

BILLING – Bill all claims to the Medicare carrier. Once Medicare payment has been received, file a Medicaid claim. Show Medicare payment, plus any penalties or outpatient psychiatric reductions, if applicable, as a third party payment on the claim form.

County-Issued Medicaid Identification Cards

The county DSS office has the authority to issue MID cards to recipients in an emergency (when the original card is incorrect or has been lost or destroyed), for new applicants or for retroactive eligibility dates. County-issued MID cards are identified by the word "EMERGENCY" stamped on the top margin of the MID card.

Verifying Eligibility

A recipient's eligibility (PCP or HMO) status may change from month to month if financial and household circumstances change. For this reason, providers should request that Medicaid recipients provide proof of eligibility each time a service is rendered. A MID card with valid from and through dates covering the date(s) of service is proof of eligibility.

If a recipient no longer meets eligibility requirements, a written notice is mailed to the recipient at least ten working days before the eligibility period ends. Should a recipient state that the MID card has not been received by mail, the provider should ask the recipient if a notice regarding a change in their eligibility status has been received. If the recipient has received a status change notice, the provider should inquire as to the nature of the change.

Recipients requesting services without proof of insurance or Medicaid coverage can be asked to pay for the services received. However, since individuals and families who are Medicaid-eligible have incomes ranging from as low as 34 percent of poverty up to 200 percent of poverty, most do not have the financial means to pay for care. Therefore, DMA provides additional methods for recipient eligibility verification.

Verification Methods

Although the recipient's MID card is the most expedient method for eligibility verification, eligibility can also be verified using the following methods:

Automated Voice Response System – Medicaid eligibility can be verified using the Automated Voice Response (AVR) system. Eligibility verification is available for services provided on the date of the inquiry as well as for services provided within the past 12 months. Refer to Appendix A for information on using the AVR system.

Electronic Data Interchange – Interactive eligibility verification programs are available from approved Electronic Data Interchange (EDI) vendors. These vendors interface directly with the Medicaid recipient database maintained by EDS. Refer to Electronic Data Interchange Services on page 10-3 for additional information.

DMA Claims Analysis – To verify eligibility for dates for service over 12 months old, contact DMA Claims Analysis at 919-855-4045.

Transfer of Assets

Medicaid reimbursement for specific home care services may be affected by the transfer of assets policy that applies to certain categories of Medicaid recipients. This policy is similar to the transfer of assets requirements currently in place for Medicaid recipients receiving nursing facility and ICF-MR care, as well as for those recipients participating in the Community Alternatives Programs.

Services Included in the Policy

The Medicaid services affected by the policy are:

Personal Care Services (PCS and PCS-Plus) in private residences

Home Health Services, including the supplies provided by home health agencies
Durable Medical Equipment (DME), including the supplies provided by DME providers
Home Infusion Therapy
Home Health fee schedule supplies provided by Private Duty Nursing (PDN) providers to PDN patients (the nursing care is not included in the policy)

Medicaid Recipients Subject to the Policy

The transfer of assets policy applies to individuals in the following Medicaid eligibility categories:
Medical Assistance for the Age (MAA)
Medical Assistance for the Disable (MAD)
Medical Assistance for the Blind (MAB)
Medicare Aid (MQB-Q)

Adult care home providers should note that this policy does not apply to their residents receiving State/County Special Assistance. It does apply to a private pay adult care home resident if the individual is in one of the four eligibility categories (MAA, MAD, MAB, and MQB-Q).

Transfer of Assets Determination

The county department of social services will make a transfer of assets determination when made aware that a recipient is seeking one of the specified home care services. After the process is completed, a determination is made that will apply to any of the specified services. A separate determination for each service is not required. The determination may result in a sanction period if the recipient has transferred assets within the time frame specified by Medicaid eligibility guidelines. Refer to the Adult Medicaid Manual, Section MA-2240 Transfer of Resources on the DMA website. The recipient is not eligible for Medicaid reimbursement of specified home care services during a sanction penalty period.

Provider Access to Transfer of Asset Information

Providers may access the Automated Voice Response (AVR) system to get a recipient's transfer of assets status as of a specified date. Refer to Section 2—Verifying Eligibility in this billing guide. Providers will receive one of the following AVR responses:

The recipient has not been assessed. The provider should ask the recipient to contact the county DSS to being a transfer of assets assessment.
The recipient is in a penalty period for the given date of service and claims for the specified services will be denied.
The recipient is not in a penalty period for the given date of service.

The AVR system provides information that is in the claims processing system at the time of the inquiry. Because a penalty period can be applied retroactively, transfer of assets information for a given date may change after the provider obtains the information.

Eligibility Denials

If claims deny for eligibility reasons, the following steps should help resolve the denial and obtain reimbursement for covered dates of service for eligible recipients.

Step 1 Check for Errors on the Claim	Step 2 Check for Data Entry Errors	Step 3 When All Information Matches
Compare the recipient's MID card to the information entered on the claim. If the information on the claim and the MID card do not match: • Correct the claim and resubmit on paper or electronically as a new day claim. If the claim is over the 365-day claim filing time limit: • Request a time limit override by submitting the claim and a completed Medicaid Resolution Inquiry form to EDS Provider Services at the address listed on the form. Include a copy of the RA or other documentation of timely filing. If the claim was originally received and processed within the 365-day claim filing time limit: • Resubmit the claim on paper or electronically as a new day claim ensuring that the recipient's MID number, provider number, from date of service, and total billed match the original claim exactly.	Compare the RA to the information entered on the claim. If the RA indicates the recipient's name, MID number or the date of service have been keyed incorrectly: • Correct the claim and resubmit on paper or electronically as a new day claim. If the claim is over the 365-day claim filing time limit, follow the instructions in Step 1 for requesting a time limit override. If the claim was originally received and processed within the 365-day claim filing time limit, follow the instructions in Step 1 for resubmitting the claim.	Verify that the recipient's eligibility information has been updated in the state eligibility file by calling the AVR system. If the AVR system indicates that the recipient is ineligible: • Submit a Medicaid Resolution Inquiry form to DMA Claims Analysis. Include a copy of the recipient's MID card, the claim, and the RA. Mail to: *DMA Claims Analysis Unit 2501 Mail Service Center Raleigh, NC 27699-2501 The Claims Analysis unit will review/update the information in EIS and resubmit the claim. **Do not mail eligibility denials to EDS as this will delay the processing of your claim.**

Refer to **Resolving Denied Claims** on page 8-1 for additional information. Refer to **Appendix A** for information on using the AVR system.

EOBs for Eligibility Denials

Article I. EOB	Message	Explanation
10	**Diagnosis or service invalid for recipient age.**	Verify the recipient's MID number, the date of birth, diagnosis, and procedure codes. Make corrections, if necessary, and resubmit to EDS as a new claim. If all information is correct, send the claim and RA to DMA Claims Analysis*.
11	**Recipient not eligible on service date.**	Follow the instructions outlined in Steps 1, 2, and 3 on page 2-10
12	**Diagnosis or service invalid for recipient sex.**	Verify the recipient's MID number, the diagnosis, and procedure codes. Make corrections, if necessary, and resubmit to EDS as a new claim. Or, if all information on the claim is correct, send the claim and the RA to DMA Claims Analysis*.
84	**Recipient is partially ineligible for service dates. Resubmit a new claim billing only eligible dates of service.**	Verify eligibility and coverage dates using the AVR system. Resubmit the claim for eligible dates of service only.
93	**Patient deceased per state eligibility file.**	Verify the recipient's MID number and the date of service. Make corrections, if necessary, and resubmit to EDS as a new claim. If the MID number and the date of service are correct, send the claim and the RA to DMA Claims Analysis*.
120	**Recipient MID number missing. Enter MID and submit as a new claim.**	Verify the recipient's MID number and enter it in the correct block or form locator. Resubmit to EDS as a new claim.
139	**Services limited to presumptive eligibility.**	Verify from the recipient's MID card that the recipient was eligible for all prenatal services, delivery, and postpartum care as well as for services required for conditions that may complicate pregnancy on the date of service. If a second "presumptive eligibility" message does not appear on the MID card, send the claim and a copy of the RA to DMA Claims Analysis*.
143	**MID number not on state eligibility file.**	Follow the instructions in Steps 1 and 2 on page 2-10. Make corrections, if necessary, and resubmit to EDS as a new claim. If the MID card is not available, obtain the recipient's correct MID number through the AVR system by using the social security number and date of birth. If the recipient's social security number is unknown, call DMA Claims Analysis* to obtain the correct MID number.
191	**MID number does not match patient name.**	Verify the recipient's name and MID number with the MID card. If all information is correct, the denial may have occurred because the recipient's name has been changed on Medicaid records since the MID card was issued. Call EDS to verify the patient's name. Correct and resubmit to EDS as a new claim.
292	**Qualified Medicare Beneficiary-MQB Recipient.**	If services billed are covered by Medicare, file charges to Medicare. **For dates of service prior to October 1, 2002,** attach the Medicare voucher to the Medicaid claim. **For dates of service after October 1, 2002,** enter the Medicare payment on the Medicaid claim. If services are not covered by Medicare, verify eligibility benefits using the AVR system to see if the recipient's eligibility has been changed to full benefits. If so, resubmit the claim to EDS. If the recipient's status is still MQB, no payment can be made by Medicaid for services not paid by Medicare. **For dates of service September 6, 2004,** attach the Medicare voucher to the Medicaid claim. Professional charges will be reimbursed a specific percentage of the coinsurance and deductible in accordance with the Part B Reimbursement schedule.

* Refer to Appendix C-5 for address.

24-Visit Limitation

Ambulatory medical visits are limited to 24 visits per year beginning July 1 of each year through June 30 of the next year. These include any one or a combination of visits to the following: physicians, clinics, optometrists, chiropractors, and podiatrists. Once this limit has been reached, claims will deny with EOB 525, "Exceeds legislative limits for provider visits for fiscal year." Providers should notify the recipient when a denial is received for exceeding the visit limits. Providers may bill the patient the usual and customary charge for the office visit.

Exemptions to the 24-visit limit include:

1. End stage renal disease.
2. Chemotherapy and/or radiation therapy for malignancy.
3. Acute sickle cell disease, hemophilia or other blood clotting disorders.
4. Services rendered to recipients under age 21.
5. Prenatal services.
6. Dental services.
7. Physician inpatient visits to patients in intermediate care facilities or skilled nursing facilities.
8. Mental health services that are subject to independent utilization review.
9. Recipients receiving Community Alternatives Program (CAP) services.
10. Recipients receiving services that are **covered by both** Medicare and Medicaid.

24-Visit Limit Exemption Requests

A provider may request an exemption from the 24-visit limit if a recipient is being treated for an illness that is imminently life threatening. The process to request an exemption usually begins when the provider receives the EOB 525 denial.

Providers must submit the request in letter form, stating the recipient's name and MID card number, and the recipient's primary diagnosis. Medical documentation supporting the exemption should be included with the request. A prescription written from the physician is unacceptable documentation and will not be accepted. The letter and denied claim, if applicable, must be sent to:

Medical Director- Dr. Durfee
EDS
P.O. Box 300001
Raleigh, NC 27622

The Medical Director reviews each request and responds in writing with either an approval or denial of the exemption. Providers who have obtained an approval will be instructed on how to code claims for processing.

Copayments

The following copayments apply to all Medicaid recipients except those specifically exempted by law from copayment:

Service	Copayment
Chiropractic	$2.00 per visit
Dental	$3.00 per visit
Prescription Drugs and Insulin	
Generic/Brand Name	$3.00 per prescription
Ophthalmologist	$3.00 per visit
Optical Supplies and Services	$2.00 per visit
Optometrist	$3.00 per visit
Outpatient	$3.00 per visit
Physician	$3.00 per visit
Podiatrist	$3.00 per visit

Providers may bill the patient for applicable copayment amounts, but may not refuse services for inability to pay the copayment. **DO NOT ENTER COPAYMENT AS A PRIOR PAYMENT ON THE CLAIM FORM.** The copayment is deducted automatically when the claim is processed.

Copayment Exemptions

Providers may not charge copayments for the following services:

- ambulance services
- dental services provided in a health department
- Diagnostic x-ray
- durable medical equipment (DME)
- family planning services
- Federally Qualified Health Center (FQHC) core services
- Health Check-related services
- hearing aid services
- HIV Case Management
- home health services
- home infusion therapy (HIT)
- hospice services
- hospital emergency department services including physician services delivered in the emergency department
- hospital inpatient services (inpatient physician services **are not** exempt)
- Laboratory services - performed in hospital
- mental health clinic services
- nonhospital dialysis facility services
- private duty nursing (PDN) services
- Rural Health Clinic (RHC) core services
- services **covered by both** Medicare and Medicaid
- services in state-owned psychiatric hospitals
- services provided to participants in the Community Alternatives Programs (CAP)
- services provided to residents of nursing facilities, intermediate care facilities for mental retardation (ICF-MR), and psychiatric hospitals
- services related to pregnancy
- services to enrollees of prepaid plans (HMOs) except services not covered under the HMO's plan such as prescriptions and dental services
- services to individuals under the age of 21